NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 12. SECRETARY OF STATE

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

Article 5	New Article
R2-12-501	New Section
R2-12-502	New Section
R2-12-503	New Section
R2-12-504	New Section

2. **The specific authority for the rulemaking, including both the authorizing statutes (general) and the statutes the rules are implementing (specific):**

   Authorizing statutes: A.R.S. § 41-121

   Implementing statutes: A.R.S. §§ 41-121 and 41-132

3. **The effective date for the rules:**

   February 19, 1999

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   None.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Michael Totherow
Address:	Office of the Secretary of State 1700 West Washington, 7th Floor Phoenix, Arizona 85007
Telephone:	(602) 542-6170
Fax:	(602) 542-1575
E-mail:	mtotherow@mail.sosaz.com
URL:	http://www.gita.state.az.us (look under news)

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   In accordance with A.R.S. § 41-121, the Secretary of State shall draft rules to accept, and approve for use, electronic digital signatures, that comply with A.R.S. § 41-132, for documents filed with and by all state agencies, boards, and commissions. In consultation with the Government Information Technology Agency, the Department of Administration and the State Treasurer, the Secretary of State shall adopt rules establishing policies and procedures for the use of electronic digital signatures, by all state agencies, boards, and commissions for documents filed with and by all state agencies, boards, and commissions.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not Applicable.

8. **A summary of the economic, small business and consumer impact:**

As stated in A.R.S. § 41-132, the Secretary of State is exempt from A.R.S. Title 41, Chapter 6; therefore an impact study was not completed.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

Not applicable.

10. **A summary of the principal comments and the agency response to them:**

This rulemaking is exempt from the requirements of A.R.S. Title 41, Chapter 6.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules.**

Not applicable.

12. **Incorporation by reference and their location in the rules.**

Not applicable.

13. **Was the rule previously adopted as an emergency rule?**

No.

14. **The full text of the rules follows:**

TITLE 2. ADMINISTRATION

CHAPTER 12. OFFICE OF THE SECRETARY OF STATE

ARTICLE 5. ELECTRONIC SIGNATURES

Section

ARTICLE 5. ELECTRONIC SIGNATURES

R2-12-501. Definitions

A. "Acceptable Certification Authorities" means authorities that meet the requirements of R2-12-504.

B. "Approved List of Certification Authorities" means the list of Certification Authorities approved by the Secretary of State to issue certificates for electronically signed transactions involving public entities in Arizona.

C. "Asymmetric crypto-system" means an electronically processed algorithm, or series of algorithms, which uses 2 different keys with the following characteristics:
   1. One key encrypts a given message;
   2. One key decrypts a given message; and
   3. The keys have the property that it is infeasible to discover 1 key from merely knowing the other key.

D. "CARAT Guidelines" means the *CARAT Guidelines - Guidelines for Constructing Policies Governing the Use of Identity-Based Public Key Certificates* drafted by the Certification Authority Rating and Trust (CARAT) Task Force of the National Automated Clearing House Association (NACHA), Version 1 Draft, September 21, 1998, excluding later amendments or additions, incorporated by reference and on file with the Secretary of State.

E. "Certificate" means an electronic document attached to a public key by a trusted certification authority, which provides proof that the public key belongs to a legitimate subscriber and has not been compromised.

F. "Certification Authority" means a person or entity that issues a certificate.

G. "Electronically signed communication" means an electronic message that has been processed in such a manner that the message is tied to the individual who signed the message.

H. "GITA" means the Government Information Technology Agency, as established by A.R.S. § 41-3501.

I. "Key pair" means a private key and its corresponding public key in an asymmetric crypto-system. The key pair is unique in that the public key can verify a digital signature that the private key creates.

J. "Message" means an electronic representation of information intended to serve as a written communication with a public entity.

K. "Person" means a human being or any organization capable of signing a document, either legally or as a matter of fact.

L. "Policy Authority" means, as defined by CARAT Guidelines, some authoritative party that formulates the guidelines defining the process of electronic signature use.

M. "Private key" means the key of a key pair used to create a digital signature.

N. "Public key" means the key of a key pair used to verify a digital signature.

O. "Public entity" means any budget unit, as defined in A.R.S. § 41-3501.

P. "S.A.S. 70" means the standards set in the American Institute of Certified Public Accounts (AICPA) Statement on Auditing Standards No. 70. Should current S.A.S. 70 standards (or any succeeding version) be superceded, the Secretary of State, in consultation with GITA and the State Treasurer, shall establish a deadline for all affected parties to comply with the replacing standard. This deadline shall be no later than 2

years from the date of issuance of the new S.A.S. standards. GITA will also provide a "roadmap" of how the revised standard fits the current Type 1 and Type 2 S.A.S. 70 designations used elsewhere in these rules.

O. "Subscriber" means a person who:
1. Is the subject listed in a certificate,
2. Accepts the certificate, and
3. Holds a private key which corresponds to a public key listed in that certificate.

R2-12-502. Identification of Acceptable Technologies for Electronic Signatures

A. The Secretary of State shall accept, and approve for use, technologies for electronic signature, in consultation with the Policy Authority and GITA, provided the technologies meet the standards set forth in the GITA standards for Electronic Signatures, as specified in A.R.S. § 41-3504.

B. Provisions for Adding New Technologies
1. Any individual or company can petition the Secretary of State to review the technology, by providing a written request for review including a full explanation of a proposed technology that meets the requirements established under subsection (A) and meets the requirements of the Policy Authority as identified in R2-12-503.
2. The Secretary of State has 180 days from the date of the request to review the petition and either accept or reject it.
a. If the petitioner's proposed technology meets the requirements established under subsection (A) and meets the requirements of the Policy Authority, then GITA shall work with the Policy Authority to incorporate the new technology into electronic signature use by public agencies in Arizona.
b. If the proposed technology is rejected, the petitioner can appeal the decision through the Administrative Procedure Act, A.R.S. § 41-1092.08(H).

R2-12-503. Policy Authority

A. The office of the Secretary of State shall serve as the Policy Authority as defined within the CARAT Guidelines. These guidelines provide a prudent operational model that may be applied to new technologies as they are approved.

B. Decisions made by the Policy Authority under A.R.S. §§ R2-12-501, R2-12-502 and R2-12-504 may be appealed pursuant to the Administrative Procedure Act, A.R.S. § 41-1092.08(H).

R2-12-504. Certification Authority Approval Application, Suspension, Revocation

A. Acceptable Certification Authorities
1. The Secretary of State shall maintain an "Approved List of Certification Authorities" authorized to issue certificates for electronically signed communication with public entities in Arizona.
2. Public entities shall only accept certificates from Certification Authorities that appear on the "Approved List of Certification Authorities" and are authorized to issue certificates by the Secretary of State.

B. Registration of Certification Authorities
1. The Secretary of State shall place Certification Authorities on the "Approved List of Certification Authorities" after the Certification Authority provides the Secretary of State with a copy of an unqualified performance audit performed in accordance with standards set in S.A.S. 70 to ensure that the Certification Authorities practices and policies are consistent with the requirements in this Article and any requirements of the Policy Authority.
a. Certification Authorities that have been in operation for 1 year or less shall undergo a S.A.S. 70 type 1 audit - A report of Policies and Procedures placed in operation, receiving an unqualified opinion.
b. Certification Authorities that have been in operation for longer than 1 year shall undergo a S.A.S. 70 type 2 audit - A Report of Policies and Procedures placed in operation and test of operating effectiveness, receiving an unqualified opinion.
c. To remain on the "Approved List of Certification Authorities", a Certification Authority must provide proof of compliance every 2 years after initially being placed on the list and meet any requirements of the Policy Authority in effect at that time.
2. In lieu of completing the auditing requirement in subsection (B)(1), Certification Authorities may be placed on the "Approved List of Certification Authorities" upon providing the Secretary of State with proof acceptable to the Secretary of State that the Certification Authority meets the Policy Authority's criteria for acceptance of a Foreign License (non-Arizona license).
a. Certification Authorities shall be removed from the "Approved List of Acceptable Certification Authorities" unless they provide current proof of accreditation to the Secretary of State at least once per year no later than December 31st of each year.
b. If the Secretary of State is informed a Certification Authority has had its accreditation revoked, the Certification Authority shall be removed from the "Approved List of Certification Authorities" immediately.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) PREMIUM SHARING DEMONSTRATION PROJECT

PREAMBLE

1. Sections Affected — Rulemaking Action

R9-30-101	Amend
R9-30-102	Amend
R9-30-103	Amend
R9-30-106	Amend
R9-30-107	Amend
R9-30-201	Amend
R9-30-204	Amend
R9-30-205	Amend
R9-30-206	Amend
R9-30-209	Amend
R9-30-210	Amend
R9-30-211	Amend
R9-30-212	Amend
R9-30-215	Amend
R9-22-216	Amend
R9-30-217	Amend
R9-30-301	Amend
R9-30-302	Repeal
R9-30-302	New Section
R9-30-303	Amend
R9-30-304	Amend
R9-30-305	Amend
R9-30-306	Amend
R9-30-401	Amend
R9-30-403	Amend
R9-30-404	Amend
R9-30-406	Amend
R9-30-407	Amend
R9-30-408	Amend
R9-30-502	Amend
R9-30-504	Amend
R9-30-507	Amend
R9-30-509	Amend
R9-30-510	Amend
R9-30-511	Amend
R9-30-512	Amend
R9-30-514	Amend
R9-30-518	Amend
R9-30-523	Amend
R9-30-601	Amend
R9-30-602	Amend
R9-30-603	Amend
R9-30-701	Amend
R9-30-702	Amend
R9-30-703	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2923 and Laws 1997, Ch. 186, § 7.

   Implementing statute: Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214, § 21; Laws 1997, Ch. 186 § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 2; and Laws 1997, Ch. 186 § 5.

3. **The effective date of the rules:**

   February 19, 1999

4. **A list of all previous notices appearing in the Register addressing the exempt rule:**
   Not applicable.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
   Name: Cheri Tomlinson, Federal and State Policy Administrator
   Address: AHCCCSA, Office of Policy Analysis and Coordination
   801 East Jefferson, Mail Drop 4200
   Phoenix, Arizona 85034
   Telephone: (602) 417-4198
   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**
   9 A.A.C. 30 details rules for the Premium Sharing Demonstration Project initiated in early 1998. The Chapter explains the project's requirements regarding scope of services, eligibility and enrollment, contracts, general provisions and standards, grievance and appeals, and payment responsibilities.

   Laws 1997, Ch. 186, § 7 exempts AHCCCS from the rulemaking requirements of Title 41, Ch. 6 for the purpose of implementing the Premium Sharing Demonstration Project.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
   Premium Share members, contractors, and the Premium Sharing Administration (PSA) will be nominally impacted and will benefit from the changes, which are designed to:

   • Make current language more understandable and concise;

   • Provide clarification to the original rule language from 1998; and

   • Update cross-references to session law.

   For example, Premium Share members and the PSA will benefit from the change to the definition of "date of application" from the date a completed PSDP application is received to the date a PSDP application is signed and dated. Under this rule change, a member will submit an application only once for the 3-month period prior to the date of application. Income information will be requested by PSA if the information was not submitted with the application. Under current rule, an application is not complete, and the application process is not started, until the PSA has received all income and verification information. The new rule allows the application process to begin when the PSA receives a signed and dated application. This rule change will also result in reduced administrative costs for the PSA.

   Other examples of changes that benefit Premium Share members, contractors, and the PSA by providing additional clarification to the rule language include:

   • R9-30-206(A) - Clarifies that dental services required prior to and associated with a transplant are covered for a Premium Share member who has a chronic illness.

   • R9-30-302 - Explains the time-frames for determining eligibility in greater detail.

   • R9-30-303(A) - Explains the types of in-kind income that are disregarded.

   • R9-30-701(G) - Clarifies the limitations on copayment requirements for laboratory visits and x-ray service.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
   Not applicable. The Administration is exempt from filing a Notice of Proposed Rulemaking for 9 A.A.C. 30, under Laws 1997, Ch. 186, § 7.

10. **A summary of the principal comments and the agency response to them:**
    The Administration received several comments regarding the substance and form of the exempt rule from the following entities: Coconino County, Mercy Care Plan, University Physicians, St. Vincent de Paul, United Community Health Center, and El Rio Health Center. Many of the comments were related to definitions, scope of services, eligibility and enrollment, grievance, and 1 comment regarding a Premium Share member's payment responsibilities.

    The Administration conducted conference calls with stakeholders to discuss their written comments. Many of the comments questioned provisions set forth in session law, and could not be changed in rule. Several requested the administration make the rules more clear, concise, and understandable. The Administration revised several sections based on these comments.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
    Not applicable.

12. Incorporations by reference and their location in the rules:
None.

13. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:
No.

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) PREMIUM SHARING DEMONSTRATION PROJECT

ARTICLE 1. DEFINITIONS

Section
R9-30-101. Location of Definitions
R9-30-102. Scope of Services Related Definitions
R9-30-103. Eligibility and Enrollment Related Definitions
R9-30-106. Grievance and Appeals Related Definitions
R9-30-107. Payment Responsibilities Related Definitions

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements
R9-30-204. Inpatient General Hospital Services
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation Services for a Chronically Ill Member
R9-30-209. Pharmaceutical Services
R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services
R9-30-211. Transportation Services
R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-30-215. Other Medical Professional Services
R9-22-216. Nursing Facility Services
R9-30-217. Behavioral Health Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements
~~R9-30-302. Submission of Application~~
R9-30-302. Time-frames for Determining Eligibility
R9-30-303. ~~Eligibility and Ineligibility Criteria~~ Conditions of Eligibility
R9-30-304. Enrollment
R9-30-305. Disenrollment
R9-30-306. Redetermination

ARTICLE 4. CONTRACTS

R9-30-401. General Provisions
R9-30-403. PSA's Contracts with Contractors
R9-30-404. Subcontracts
R9-30-406. ~~Mergers; Reorganizations; Change;~~ Merger, Reorganization, Change in Ownership, and Contract Amendments
R9-30-407. ~~Suspension; Denial; Modification;~~ Suspension, Modification, or Termination of Contract
R9-30-408. Contract Compliance Sanction Alternative

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-502. Availability and Accessibility of Services
R9-30-504. Marketing
R9-30-507. Member Record
R9-30-509. Transition and Coordination of Member Care
R9-30-510. Transfer of a Member
R9-30-511. Fraud and Abuse
R9-30-512. Release of Safeguarded Information by the PSA and a Contractor
R9-30-514. Equal Opportunity
R9-30-518. Information to an Enrolled Member
R9-30-523. Financial Resources

ARTICLE 6. GRIEVANCE AND APPEALS

R9-30-60. General Provisions for all Grievances and Appeals
R9-30-602. Eligibility Appeals and Hearing Requests for an Applicant and a Premium Share Member
R9-30-603. Grievances

ARTICLE 7. PAYMENT RESPONSIBILITIES

R9-30-701. A Premium Share Member's Payment Responsibilities
R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors
R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

ARTICLE 1. DEFINITIONS

R9-30-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 30 are found in the following:

Definition	Section or Citation
1. "AHCCCS"	R9-22-101
2. "Ambulance"	R9-22-102
3. "Applicant"	R9-30-101
4. "Chronic disease"	R9-30-102
5. "Chronically ill ~~person~~" member"	R9-30-102
6. "Clean claim"	A.R.S. § 36-2904
~~7. "Completed premium sharing application"~~	~~R9-30-103~~
~~8.~~ 7. "Contractor"	R9-22-101
~~9.~~ 8. "Copayment"	R9-30-107
~~10.~~ 9. "Covered services"	R9-30-102
~~11. "Day"~~	~~R9-22-101~~
~~12.~~ 10. "Date of application"	R9-30-103
11. "Day"	R9-22-101
~~13.~~ 12. "Eligible for AHCCCS benefits"	R9-30-103
~~14.~~ 13. "Emergency medical services"	R9-22-102
~~15. "Enrollee"~~	~~Laws 1997, Ch. 186 § 3~~
~~16.~~ 14. "Enrollment"	R9-30-103
~~17.~~ 15. "E.P.S.D.T. services"	R9-22-102
~~18.~~ 16. "FPL"	R9-30-103
~~19.~~ 17. "Fund"	A.R.S. § 36-2923
~~20.~~ 18. "Grievance"	R9-30-106
~~21.~~ 19. ~~"Head of household"~~ "Head-of-household"	R9-30-103
~~22.~~ 20. "Hospital"	R9-22-101
~~23.~~ 21. "Household income"	R9-30-103
~~24.~~ 22. "Household unit"	R9-30-103
~~25.~~ 23. "Inpatient hospital services"	R9-30-101
~~26.~~ 24. "Life threatening"	R9-27-102

~~27.~~ 25. "Medical record"	R9-22-101
~~28.~~ 26. "Medical services"	R9-22-101
~~29.~~ 27. "Medically necessary"	R9-22-101
~~30.~~ 28. "Month of application"	R9-30-103
~~31.~~ 29. "Noncontracting provider"	A.R.S. § 36-2931
30. "Offeror"	R9-22-106
~~32.~~ 31. "Other health care practitioner"	~~R9-27-102~~R9-27-101
~~33.~~ 32. "Outpatient hospital services"	R9-22-107
~~34.~~ 33. "Pharmaceutical services"	R9-22-102
~~35.~~ 34. "Plan"	~~Laws 1997, Ch. 186 § 3~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21
~~36.~~ 35. "Population"	~~Laws 1997, Ch. 186 § 3~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21
~~37.~~ 36. "Practitioner"	R9-22-102
~~38.~~ 37. "Premium"	R9-30-107
~~39. "Pre-existing condition"~~	~~R9-30-102~~
~~40.~~ 38. "Premium Share"	R9-30-107
~~41.~~ 39. "Premium Share member"	R9-30-103
~~42.~~ 40. "Pre-payment"	R9-30-107
~~43. "PSA"~~	~~R9-30-101~~
~~44. "PSDP"~~	~~R9-30-101~~
~~45. "Pre-payment"~~	~~R9-30-107~~
~~46.~~ 41. "Prescription"	R9-22-102
~~47.~~ 42. "Primary care provider"	R9-22-102
~~48.~~ 43. "Prior authorization"	R9-22-102
~~49.~~ 44. "Providers"	A.R.S. § 36-2901
45. "PSA"	R9-30-101
46. "PSDP"	R9-30-101
~~50.~~ 47. "Quality management"	R9-22-105
~~51.~~ 48. "Redetermination"	R9-30-103
~~52.~~ 49. "Referral"	R9-22-101
~~53.~~ 50. "RFP"	R9-22-105
~~54.~~ 51. "Service area"	~~R9-27-101~~ R9-30-103
~~55.~~ 52. "Scope of ~~Services"~~ services"	R9-22-101
~~56.~~ 53. "Subcontract"	R9-22-101
~~57.~~ 54. "System"	A.R.S. § 36-2901
~~58.~~ 55. "Utilization management"	R9-22-105

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Applicant" means a person who submits, or on whose behalf is submitted, a ~~written, signed,~~ signed and dated application for ~~PSDP benefits which has been either completed or denied~~. enrollment in the PSDP.
2. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a Premium Share member's primary care provider.
3. "PSA" means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to carry out the administrative functions of the PSDP ~~according to Laws 1997, Ch. 186 § 3.~~ under Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
4. "PSDP" means Premium Sharing Demonstration Project, which is a 3-year pilot program established ~~according to~~ under A.R.S. § 36-2923.

R9-30-102. Scope of Services Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Chronic disease" means a ~~non-acute~~ nonacute condition that is not caused by alcohol, drug, or chemical addiction, and if not treated, has a reasonable medical probability of causing a life-threatening situation or death. For the purposes of the PSDP, chronic disease includes only the following diagnoses as specified in ~~Laws 1997, Ch. 186, §§ 3 and 4, as amended by Laws 1997, 2nd Special Session, Chapter 186 §§ 3 and 4;~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21;
   a. Alpha-1-Antitrypsin Deficiency,
   b. Amytrophic ~~Lateral Sclerosis~~ lateral sclerosis (Lou Gehrig's Disease),
   c. Cardiomyopathy,
   d. Chronic ~~Liver Disease,~~ liver disease,
   e. Chronic ~~Pancreatitis,~~ pancreatitis,
   f. Chronic ~~Rheumatoid Arthritis,~~ rheumatoid arthritis,
   g. Congenital ~~Heart Disease,~~ heart disease,
   h. Cystic ~~Fibrosis,~~ fibrosis,
   i. Growth ~~Hormone Deficiency,~~ hormone deficiency,
   j. Hematologic ~~Cancer Patients,~~ cancer patients,
   k. Hemophilia,
   l. History of any ~~Solid Organ Transplant,~~ solid organ transplant,
   m. ~~HIV/Acquired Immunodeficiency Syndrome,~~ AIDS,
   n. Hodgkin's ~~Disease,~~ disease,
   o. Metastatic ~~Cancer,~~ cancer,
   p. Multiple ~~Sclerosis,~~ sclerosis,
   q. Muscular ~~Dystrophy,~~ dystrophy,
   r. Pulmonary ~~Hypertension,~~ hypertension, and
   s. Sickle ~~Cell Disease.~~ cell disease.
2. "Chronically ill ~~person~~" member" means a person enrolled with PSDP, who has been diagnosed with a chronic disease as defined in ~~this Section~~ subsection (1) and who has an annual gross household income at or below 400% of the FPL ~~and who has been eligible for health care services according to A.R.S. § 11-297, for 12 consecutive months out of 15 consecutive months immediately preceding the date of application for the PSDP.~~ as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
3. "Covered services" means the health and medical services specified in Article 2 of this Chapter. ~~9 A.A.C. 30, Article 2.~~
4. ~~"Pre-existing condition" means an illness or injury that is diagnosed or treated within a 6 month period preceding the effective date of coverage.~~

R9-30-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

~~1. "Completed premium sharing application" means a PSDP application form, signed and dated by the head of~~

~~household with all questions answered and accompanied by all documentation required to verify the information.~~

~~2.~~ 1. "Date of application" means the date a ~~complete~~ signed and dated PSDP application is received in the PSA office.

~~3.~~ 2. "Eligible for AHCCCS benefits" means enrolled as a member of the Arizona Health Care Cost Containment System, beginning the 1st day of the month following the date a person has been determined eligible under A.R.S. § 36-2901(4)(a), (b), (c), and (h).

~~4.~~ 3. "Enrollment" means the process by which ~~an individual~~ a person applies for coverage, is determined eligible, selects a PSDP contractor, and begins making premium payments to the ~~PSA in order to receive services, if medically necessary, through a PSDP contractor~~. PSA.

~~5.~~ 4. "FPL" means the federal poverty level, ~~or otherwise known as~~ the federal poverty guidelines published annually by the United States Department of Health and Human Services.

~~6.~~ 5. "~~Head of household~~" "Head-of-household" means the household member who assumes the responsibility for providing PSDP eligibility information for the household unit in accordance with Article 3 of this Chapter. ~~9 A.A.C. 30, Article 3.~~ The head-of-household may designate a nonhousehold member as the household's representative.

~~7.~~ 6. "Household income" means the total gross amount of all money received by all eligible or ineligible household members such as cash, a check, ~~or their similar instrument,~~ a cashier's check, a money order, or as ~~deposits~~ a deposit into the household member's solely or jointly owned financial account.

~~8.~~ 7. "Household unit" means 1 or more ~~individuals~~ persons who reside together in a household and are considered in determining eligibility.

~~9.~~ 8. "Month of application" means the calendar month during which a ~~completed~~ signed and dated PSDP application is ~~received in the PSA office.~~ postmarked if mailed or, if hand-delivered, the date of actual delivery.

~~10.~~ 9. "Premium Share member" ~~means any member of the household unit who is enrolled in the PSDP~~ means an enrollee as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

~~11.~~ 10. "Redetermination" means the periodic submission of a ~~new, complete~~ PSDP redetermination form ~~application~~ by a current Premium Share member requesting continuation of PSDP coverage, and the review of that application and determination of ongoing eligibility and premium by the PSA.

11. "Service area" means the area for which a contractor has contracted with AHCCCS to provide services to Premium Share members.

R9-30-106. Grievance and Appeals Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another ~~meaning.~~ meaning: "Grievance" means a complaint initiated in accordance with Article 6 of this Chapter. ~~9 A.A.C. 30, Article 6.~~

R9-30-107. Payment Responsibilities Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Copayment" means a monetary amount a ~~enrollee~~ Premium Share member pays directly to a provider at the time a covered ~~services are~~ service is rendered.
2. "Premium" means the total amount due monthly for the provision of covered services to ~~enrollees~~ Premium Share members.
3. "Premium share" means the portion of the premium, not to exceed 4% of the Premium Share member's gross annual household income, ~~an enrollee~~ a Premium Share member whose household income is equal to or less than 200% of FPL must pay monthly for the provision of covered ~~services who is at or below 200% of FPL.~~ services.
4. "Pre-payment" means submission of the ~~enrollee's~~ Premium Share household's share of the ~~premium~~ premium. The pre-payment is due 30 days ~~in advance of~~ before the effective date of coverage.

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements

A. In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:

1. Covered services provided to a Premium Share member shall be medically necessary and provided ~~by,~~ by or under the direction of a primary care provider or dentist; specialist services shall be provided under referral ~~from,~~ from and in consultation ~~with,~~ with the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a Premium Share member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from, and in consultation with, the primary care provider, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral ~~requirements;~~ requirements.
2. Behavioral health services are limited to 30 days of inpatient care and 30 outpatient visits ~~annually~~ per contract year as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
3. Services shall be rendered in accordance with state laws and regulations, the *Arizona Administrative ~~Code~~ Code*, and PSA contractual ~~requirements;~~ requirements.
4. Experimental services as determined by the ~~Director,~~ Director or services provided primarily for the purpose of research, shall not be ~~covered;~~ covered.
5. PSDP services shall be limited to those services that are not covered for a Premium Share member who is covered by another funding source as specified in ~~R9-30-301;~~ R9-30-301.
6. Services or items, if furnished gratuitously, are not covered and payment shall be ~~denied;~~ denied.
7. Personal care items are not covered and payment shall be ~~denied;~~ denied.
8. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;

b. A person who is in residence at an institution for the treatment of tuberculosis; or
c. A person who is in an institution for the treatment of a mental ~~disorders;~~ disorder, unless provided ~~according to~~ under this Article.

B. The PSA may require that providers be AHCCCS registered. Services may be provided by AHCCCS registered personnel or facilities that meet state ~~requirements;~~ requirements and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization ~~by the contractor~~ is not obtained from the contractor. Emergency services ~~under A.R.S. § 36-2908~~ as defined in R9-22-102(7) do not require prior ~~authorization;~~ authorization; however, the Premium Share member must notify the contractor as required in R9-30-210(C).
1. ~~For a Premium Share member, the contractor shall prior authorize services~~ The contractor shall prior authorize services for a Premium Share member based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the Premium Share member's primary care provider or dentist.
2. Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.
3. In addition to the requirements of Article 7 of this Chapter ~~9 A.A.C. 30, Article 7~~, written documentation of diagnosis and treatment may be required for reimbursement for services that require prior authorization.

D. ~~Covered services~~ A covered service rendered to a Premium Share member shall be provided within the service area of the Premium Share member's ~~primary~~ contractor except when:
1. A primary care provider refers a Premium Share member out of the contractor's area for medical specialty care with health plan approval;
2. A covered service that is medically necessary for a Premium Share member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a Premium Share member or the Premium Share member's household;
4. A Premium Share member is placed in a nursing facility located out of the contractor's service ~~area;~~ area with health plan approval;
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service ~~considerations.~~ considerations; or
6. The service is an emergency service as defined in R9-30-210.

E. When a Premium Share member is traveling or temporarily ~~residing out~~ outside of the service area of the Premium Share member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. The Director shall determine the circumstances under which a Premium Share member may receive services, other than emergency ~~services,~~ services as specified in subsection (E), from service providers outside the Premium Share member's county of residence or outside the state. Criteria considered by the Director in making this determination shall include availability, accessibility of appropriate care, and cost effectiveness.

H. If a Premium Share member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services prior authorized by the health plan for the Premium Share member during that time.

I. The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any ~~non-covered~~ noncovered service to a Premium Share member and shall not be included in development or negotiation of capitation.

J. ~~In accordance with~~ Under A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors, modify the list of services for all Premium Share members.

K. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay a copayment in full at the time the service is rendered as specified ~~on~~ in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

~~L. A pregnancy shall not be considered a pre-existing condition for the purposes of refusing services as specified in Laws 1997, Ch. 186 § 3.~~

R9-30-204. Inpatient General Hospital Services

A. The contractor shall provide inpatient general hospital accommodations and appropriate staffing, supplies, equipment, and services for:
1. Maternity ~~care;~~ care,
2. Neonatal intensive care ~~(NICU);~~ (NICU),
3. Intensive care ~~(ICU);~~ (ICU),
4. ~~Surgery;~~ Surgery,
5. ~~Nursery;~~ Nursery,
6. Routine ~~care;~~ care, and
7. Behavioral health (psychiatric) care.
   a. A Premium Share member is eligible for a maximum of 30 days of ~~inpatient~~ inpatient behavioral health services ~~annually~~ per contract year as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
   b. For the purpose of this Section, the PSDP contract year shall be October 1 through September 30.

B. The contractor shall provide ancillary services as specified by the Director and included in contract:
1. Labor, delivery, recovery rooms, and birthing centers;
2. Surgery and recovery rooms;
3. Laboratory services;
4. Radiological and medical imaging services;
5. Anesthesiology services;
6. Rehabilitation services;
7. Pharmaceutical services and prescribed drugs;
8. Respiratory therapy;
9. Blood and blood derivatives;
10. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
11. Maternity services; and
12. Nursery and related services.

R9-30-205. Primary Care Provider Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a Premium Share member when rendered within the provider's scope of prac-

tice under A.R.S. Title 32. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:

1. Periodic health examinations and ~~assessments;~~ assessments,
2. Evaluations and diagnostic ~~workups;~~ workups,
3. Medically necessary ~~treatment;~~ treatment,
4. Prescriptions for medications and medically necessary supplies and ~~equipment;~~ equipment,
5. Referrals to specialists or other health care professionals when medically ~~necessary;~~ necessary,
6. Patient ~~education;~~ education,
7. Home visits when determined medically ~~necessary;~~ necessary,
8. Covered ~~immunizations;~~ immunizations,
9. Covered preventive health services.

B. The following limitations and exclusions apply to primary care provider services:

1. Specialty care and other services provided to a Premium Share member upon referral from a primary care provider ~~or to a Premium Share member upon referral from the primary care provider~~ shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the Premium Share member's contractor, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing 3rd-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection ~~(A).~~ (A);
3. Orthognathic surgery shall be covered only for a Premium Share member who is less than 21 years of age; and
4. The following services shall be excluded from PSDP coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Abortion counseling services;
   c. Abortions, unless authorized under state law, as specified in A.R.S. § 36-2903.01;
   d. Services or items furnished solely for cosmetic purposes;
   e. Hysterectomies unless determined to be medically necessary;
   f. Elective surgeries with the exception of voluntary sterilization procedures; and
   g. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-30-206. Organ and Tissue Transplantation Services for a Chronically Ill Member

A. A Premium Share member who has a chronic illness as specified in ~~Laws 1997, Ch. 186 §§ 3 and 4, as amended by Laws 1997, 2nd Special Session, Chapter 186, §§ 3 and 4,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, is eligible for the following organ and tissue transplantation services as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the Premium Share member's ~~contractor for a Premium Share member:~~ contractor:
   1. Kidney transplantation;
   2. Cornea transplantation;
   3. Heart transplantation;
   4. Liver transplantation;
   5. Autologous and allogeneic bone marrow transplantation;
   6. Lung transplantation;
   7. Heart-lung transplantation;
   8. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
   9. Immunosuppressant medications, chemotherapy, and other related services including medically necessary dental services required prior to and associated with a transplant.

B. Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

R9-30-209. Pharmaceutical Services

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a Premium Share member's residence.

C. Pharmaceutical services shall be covered ~~if prescribed for a Premium Share member by: the Premium Share member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider or dentist unless referral is waived by the contractor and~~ upon authorization by the contractor or its designee's ~~formulary.~~ formulary if prescribed for a Premium Share member by:
   1. The Premium Share member's primary care provider or dentist;
   2. A specialist, upon referral from the premium Share member's primary care provider or dentist; or
   3. A specialist without a referral by the Premium Share member's primary care provider or dentist if the contractor has waived the referral requirement.

D. The following limitations shall apply to pharmaceutical services:
   1. A medication personally dispensed by a primary care provider or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
   2. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
      a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
      b. The Premium Share member will be out of the contractor's service area for an extended period of time and the prescription is limited to the extended time

period, not to exceed 100 days or 100-unit dose, whichever is more.

3. A nonprescription medication is not covered unless the nonprescription medication is an ~~appropriate,~~ appropriate alternative ~~over-the-counter~~ medication ~~is available~~ and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill is dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes ~~in,~~ in or additions ~~to,~~ to an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a Premium Share member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services

A. Emergency medical services and emergency behavioral health services ~~may~~ shall be provided to a Premium Share member by licensed providers.

B. Emergency medical services and emergency behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area.

C. The Premium Share member shall notify the contractor within 48 hours after the initiation of treatment. If a Premium Share member is incapacitated, the provider is responsible for notifying the contractor within 48 hours after the initiation of treatment. Failure of the Premium Share member or provider to notify the contractor as required ~~shall~~ may result in denial of payment.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

E. Emergency services do not require prior authorization.

1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a Premium Share member shall notify the Premium Share member's contractor within 12 hours of the time the Premium Share member presents for services;
2. If a Premium Share member's medical condition is determined not to be an emergency medical condition as defined in A.A.C. R9-22-101, the provider shall notify the Premium Share member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the Premium Share member's nonemergency condition. Failure by the provider to provide timely notice or to comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

R9-30-211. Transportation Services

A. Emergency ambulance services.

1. Emergency ambulance transportation shall be a covered service for a Premium Share member. Payment shall be limited to the cost of transporting the Premium Share member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the Premium Share member's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed according to the terms and conditions that the PSA specified in the contractor's contract, if the medical condition at the time of transport justified a medically necessary or emergency ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the Premium Share member at the time of transport.
4. A ground or air ambulance provider furnishing transportation in response to a 911 call or other emergency response system shall notify the Premium Share member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.

B. Medically necessary nonemergency transportation. A Premium Share member is responsible for the full cost of any nonemergency transportation as specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, except as specified in subsection (A) ~~of this Section~~.

R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:

1. Prescribed for a Premium Share member by the Premium Share member's primary care provider, unless referral is waived by the contractor; or
2. Provided in compliance with requirements of this Chapter; and
3. Provided in compliance with the contractor's requirements.

B. Medical supplies include consumable items covered under Medicare that are provided to a Premium Share member and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a Premium Share member.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a Premium Share member.

E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction.

F. The following limitations apply:

1. If medical equipment can not be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the Premium Share member's primary care provider or authorized ~~pre-~~

~~scriber, or prior authorized by the PSA for Premium Share members,~~ prescriber and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the Premium Share member's contractor, without prior written notification of the change or addition.

4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the Premium Share member no longer needs the medical equipment;
   b. When the Premium Share member is no longer eligible for PSDP services; or
   c. When the Premium Share member is no longer enrolled with a contractor, with the exception of transition of care as specified by the Director.
5. Personal ~~incidentals~~ incidentals, including items for personal cleanliness, body hygiene, and ~~grooming~~ grooming, shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First ~~1st~~ aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for a Premium Share member who is 21 years of age and older, unless authorized under subsection (E).

G. Liability and ownership.
1. Purchased durable medical equipment provided by a contractor for a Premium Share member, but which is no longer needed, may be disposed of in accordance with each contractor's policy.
2. The contractor shall retain title to purchased durable medical equipment supplied to a Premium Share member who becomes ineligible or no longer requires its use.
3. If customized durable medical equipment is purchased by the contractor for a Premium ~~Sharing member by the contractor,~~ Share member, the equipment will remain with the person during times of ~~transition,~~ transition or ~~upon loss of eligibility.~~ if person becomes ineligible.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a Premium Share member's medical needs and which, most likely, cannot be used or reused to meet the needs of another ~~individual.~~ person.
   b. Customized equipment obtained fraudulently by a Premium Share member shall be returned for disposal to the Premium Share member's contractor if the customized equipment was purchased for a Premium Share member.

R9-30-215. Other Medical Professional Services

A. The following medical professional services provided to a Premium Share member by a contractor, shall be covered services when provided in an inpatient, outpatient, or office setting within the limitations specified below:
1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV/AIDS blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife ~~service~~ services for prenatal care and home births in low risk ~~pregnancies,~~ pregnancies if the contractor chooses to provide such services;
5. Podiatry services when ordered by a Premium Share member's primary care provider;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services;
12. Chemotherapy; and
13. A Premium Share member is eligible for a maximum 30 days of inpatient and of 30 outpatient behavioral health visits ~~annually~~ per contract year as specified in ~~Laws 1997, Ch 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

B. The following shall be excluded as PSDP covered services:
1. Occupational and speech therapies provided on an outpatient basis for a Premium Share member who is 21 years of age or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

R9-30-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a Premium Share member would require hospitalization ~~is that,~~ if nursing facility services ~~are~~ were not ~~provided, hospitalization of the individual would result.~~ provided.

B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
   a. Administration of medication;
   b. Tube feedings;
   c. Personal care services (assistance with bathing and grooming);
   d. Routine testing of vital signs; and
   e. Maintenance of catheters;
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First ~~1st~~ aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (nonsterile);
   h. Laxatives;

i. Beds and accessories;
j. Thermometers;
k. Ice bags;
l. Rubber sheeting;
m. Passive restraints;
n. Glycerin swabs;
o. Facial tissue;
p. Enemas;
q. Heating pads;
r. Diapers; and
s. Alcoholic beverages;

3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and durable medical equipment.

C. Each admission shall be prior authorized by the contractor for a Premium Share member.

R9-30-217. Behavioral Health Services

A. General ~~Requirements.~~ requirements. A Premium Share member with a behavioral or substance abuse disorder shall be eligible for behavioral health services with the limitations of 30 days of inpatient and 30 outpatient visits ~~annually~~ per contract year as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

B. Service ~~Delivery System and Referral.~~ delivery system and referral. A contractor shall be responsible for the provision of medically necessary behavioral health services to a Premium Share member.

C. Covered ~~Behavioral Health Services~~ behavioral health services for a Premium Share member:

1. The following requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations.
   a. The service shall be medically necessary, cost effective, and PSDP reimbursable;
   b. The service shall be provided by qualified service providers as specified in contract;
   c. A service provider, as applicable, shall contract with a contractor;
   d. A ~~services~~ service shall be authorized, as applicable, by the contractor; and
   e. ~~Services~~ A service shall be provided in appropriate residential settings which meet state licensing standards;
2. The following behavioral health services shall be covered, subject to the limitations and exclusions in the contract:
   a. Inpatient ~~services;~~ services,
   b. Professional ~~services;~~ services,
   c. Rehabilitation ~~services;~~ services,
   d. Evaluation and case management ~~services;~~ services,
   e. Behavioral health-related ~~services;~~ services,
   f. Emergency transportation ~~services;~~ services,
   g. Qualifications and standards of participation for service ~~providers;~~ providers, and
   h. Utilization control.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

A. Expenditure limit. Enrollment in the PSDP is limited to funding as specified in ~~Laws 1997, Ch. 186 §§ 3 and 4, as amended by Laws 1997, 2nd Special Session Ch. 186 §§ 3 and 4.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21 and Laws 1997, Ch. 186 § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 2. The PSA will accept ~~enrollees~~ members subject to the availability of funds. ~~Applicants will~~ A person determined eligible shall be placed on a waiting list after it is estimated that 80% of the annual expenditures will be reached. When funding becomes available, ~~individuals~~ persons on the waiting list will be contacted and asked to ~~submit a new application if~~ update the original application if it is more than 60 days old. Spaces will be filled ~~as the complete applications are received.~~ in the order that the applicants are determined eligible.

B. Participation. Subject to the expenditure limitation specified in subsection ~~(A),~~ (A) and the cap and waiting list requirements in subsection (D), a person who meets all eligibility requirements ~~and who is not chronically ill, may~~ shall be approved and ~~shall:~~ shall pay:

~~1. Pay a premium;~~
~~2~~ 1. ~~Pay a copayment;~~ A copayment every time a service is received, and
2. A monthly income-based premium.
~~3. Have income at or below 200% FPL.~~

C. Health history questionnaire. An applicant who has been determined eligible for the PSDP shall receive a health history questionnaire which must be completed by each eligible household member and returned with the 1st premium payment for each household member to be enrolled in the PSDP.

D. Chronically ill cap and waiting list.

1. The PSA shall limit the total number of all chronically ill ~~enrollees~~ members in the PSDP to 200 persons as specified in ~~Laws 1997, Ch. 186 §§ 3 and 4 as amended by Laws 1997, 2nd Special Session, Ch. 186 §§ 3 and 4.~~ Laws 1997, Ch. 186 § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 2. When the PSDP has reached this limitation, and subject to the expenditure limit as specified in subsection (A), ~~applicants will~~ persons determined eligible shall be placed on a waiting list. When funding becomes available, ~~individuals~~ persons on the waiting list will be contacted, and asked to ~~submit a new application if~~ update the original application if it is more than 60 days old. Spaces will be filled ~~as the complete applications are received.~~ in the order that the applicants are determined eligible.
2. The chronic illness cap applies to all chronically ill persons whose gross household income does not exceed 400% of FPL.

~~**R9-30-302. Submission of Application**~~

~~A. Applications. The PSA will not accept an application until the application is complete. The PSA will return incomplete applications to the applicant. For an application to be complete:~~

~~1. All questions must be answered; and~~
~~2. All necessary verification shall be attached to the application.~~

~~B. Returned applications. The PSA shall return incomplete applications only twice. The returned applications must be received by the PSA within 60 days of the initial application or a new application shall be required.~~

R9-30-302. Time-frames for Determining Eligibility

A. Within 20 days following receipt of application, the PSA shall review the application and contact the applicant if additional information and verification is needed to complete the eligibility determination.

B. Provisions of verification:
1. Applicants shall provide the PSA with information and corresponding verification requested in subsection (A) within 10 days following the date the information and verification was 1st requested by the PSA.
2. The PSA shall extend the time period by 10 days if before the expiration of the time period allotted in subsection (B)(1) the head-of-household requests additional time.

C. The PSA shall determine eligibility within 20 days from the date all information necessary to determine eligibility is received by PSA.

R9-30-303. ~~Eligibility and Ineligibility Criteria~~ Conditions of Eligibility

A. ~~PSDP general requirements for eligibility and ineligibility.~~ General eligibility requirements for the chronically ill member and the nonchronically ill member.
1. Citizenship/alien status. ~~To participate in the PSDP, an~~ An applicant shall meet 1 of the following citizenship requirements:
   a. Be a United States citizen as specified in A.R.S § 36-2903.01 and ~~Laws 1997, Ch. 186 § 3;~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21; or
   b. Be a qualified alien as specified in A.R.S. § ~~36-2903.01;~~ 36-2903.01.
2. Residency. An applicant shall be a resident of Arizona as specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, and a primary resident of 1 of the ~~counties served by the pilot which include~~: following:
   a. Cochise ~~county;~~ County;
   b. Maricopa ~~county;~~ County;
   c. Pima ~~county;~~ County; or
   d. Pinal ~~county;~~ County.
3. Income.
   a. The PSA ~~will annualize~~ shall determine the gross household income from documentation submitted by the applicant that identifies income received by all household members during the 3 full calendar months immediately ~~before~~ prior to the month of ~~application; and~~ application.
   b. The PSA ~~will~~ shall count gross income from employment, self-employment, rental, public assistance benefits, other earned and unearned ~~income as specified in the PSDP policy manual.~~ income.
   c. The following amounts shall be deducted from the gross household income:
      i. Payments paid to cover the costs of doing business, and
      ii. Payments paid to cover the costs of producing income from rental property as specified in the PSDP policy manual, and
      iii. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered.
   d. The following in-kind income shall be disregarded:
1. Food stamps,
2. Earned income tax credits, and
3. Certain lump sum payments.
4. ~~Deductions from income. The PSA allows deductions from the gross income only for:~~
   ~~a. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered; or~~
   ~~b. Payments made to cover the costs of doing business and payments made to cover the costs of producing income from rental property as specified in the PSDP policy manual;~~
5. ~~Income disregards. The PSA does not disregard other income for PSDP eligibility;~~
6.4. Income limits. The annualized gross household income, less deductions shall not exceed 200% of the FPL as specified in ~~Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3 or~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21 for a nonchronically ill member and 400% FPL for a chronically ill ~~person;~~ person.
7.5. Income verification. ~~Verification for all sources of income shall be provided for all household members for the 3 calendar months before the month of application.~~
   ~~a. The PSA shall review provided verification of the gross amount of income and the date the income was paid to the household member as specified in subsection (A)(3); and~~
   a. The applicant shall provide verification for all sources of income received by all household members from all sources during the 3 full calendar months prior to the month of application.
   b. ~~When~~ If the applicant fails to provide verification of income, the application ~~is incomplete and will not be accepted;~~ shall be denied.
8.6. Household composition. The PSA determines eligibility by household unit. ~~Members~~ All members of the ~~same~~ household must be included on the application. The following ~~individuals~~ persons, when living together, are members of the same household:
   a. ~~Head of household;~~ Head-of-household;
   b. A legal spouse of the ~~head of household.~~ head-of-household. This includes spouses who are temporarily away from the home due to employment or who are seeking ~~employment within Arizona;~~ employment.
   c. A common-law spouse of the ~~head of household.~~ head-of-household. A common-law spouse is a legal spouse when the applicant and spouse have lived together in, and met the requirements for, common-law marriage in a state that recognizes these marriages;
   d. Other parent. The other parent or guardian of a common dependent child when that person is not the spouse of the ~~head of household.~~ head-of-household; and
   e. A dependent child. A dependent child who is unmarried, has not reached age 19, and is a ~~natural~~ biological child, adopted child, a step-child of the

~~head of household~~ head-of-household or spouse or both, or the ~~natural~~ biological child of another dependent child who is a household member, a ~~child supported by the head of household or spouse or both as a result of a court order,~~ or a child for whom the ~~head of household~~ head-of-household or spouse is a legal guardian unless that child's adult arent is sharing the ~~residence;~~ residence.

~~9.~~7. Cooperation. An applicant shall cooperate in providing the necessary information to verify ~~eligibility:~~ eligibility.

~~10.~~8. Fraud. An applicant who has been convicted of fraud or abuse in the following programs in any state is not eligible to participate in the Premium Sharing Demonstration Program:

~~a.~~ ~~The PSDP;~~
~~b.~~ a. Temporary Assistance to Needy Families (TANF);
~~c.~~ b. Aid to Families with Dependent Children (AFDC);
~~d.~~ c. General Assistance (GA);
d. KidsCare;
e. ~~Foodstamps~~ Food Stamps;
f. ~~Medicaid;~~ Programs established under Title XIX of the Social Security Act; or
g. State or county sponsored medical assistance programs~~; and~~ programs.

~~11~~9. Other health care coverage. ~~An~~ Except as provided in subsection (B), an applicant who is currently insured, or who has had health care coverage other than AHCCCS in the 6 months prior to application for the PSDP, is not eligible for coverage under the PSDP, as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

10. Other limitations.
a. Veterans Administration (VA) coverage. An applicant who has VA coverage for a medical condition is not eligible for coverage of only that medical condition or medical conditions under the PSDP.
b. Medicare benefits. An applicant who has Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSDP.
c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits or KidsCare under A.R.S. Title 11, Chapter 2, or A.R.S. Title 36, Chapter 29, is not eligible for the PSDP. The PSA may screen an application to determine if an applicant is eligible for any of these programs. An applicant shall declare whether the applicant has been determined ineligible for these programs. An applicant is encouraged to apply for AHCCCS benefits or KidsCare prior to approval for the PSDP.
d. Exceptions to AHCCCS benefits. Women who are eligible for family planning assistance under the Sixth Omnibus ~~Budge~~ Budget Reconciliation Act (SOBRA) may apply for the PSDP as specified in ~~Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
~~e. State Children's Health Insurance Program (SCHIP). A child who is eligible for SCHIP is eligible for participation in the PSDP for a limited time as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.~~
~~f.~~e. Payor of last resort. The PSA contractor shall not be the primary payor for any claim involving ~~workers~~ worker's compensation, automobile insurance, or homeowner's insurance.

B. Requirements for a chronically ill ~~person.~~ member.
~~1. General Requirements. A chronically ill applicant shall meet the requirements in subsection (A)(1) through (11).~~
1. Limited enrollment. There is a 200-space limit for the chronically ill. An applicant shall be placed on a waiting list once the spaces are filled or expenditure limits are reached as specified in subsection (A)(1) and Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21 and Laws 1997, Ch. 186 § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 2.
2. Other health care coverage. ~~The restriction on an applicant who has had health care coverage as specified in subsection (A)(11) does not apply to a chronically ill person.~~ The requirements in subsection (A)(9) do not apply to a chronically ill member who has an annual gross household income equal to or greater than 200% but equal to or less than 400% of FPL.
3. Chronic illness coverage. The following limitations shall apply for any applicant who meets the requirements for coverage as a chronically ill ~~person~~ member as specified in R9-30-102.
~~a. Limited enrollment. There is a 200-space limit for the chronically ill. An applicant shall be placed on a waiting list once the spaces are filled or expenditure limits are reached as specified in subsection (A)(1) and Laws 1997, Ch. 186 §§ 3 and 4, as amended by Laws 1997, 2nd Special Session, Ch. 186 § and 4.~~
~~b. Continuous AHCCCS coverage. A chronically ill applicant whose gross household income exceeds 200% of the FPL but does not exceed 400% of the FPL shall have been receiving services under A.R.S § 11-297 for at least 12 of the 15 months preceding the month of application~~
~~b.~~ a. Continuous AHCCCS coverage. As a condition of eligibility, an applicant with an annual gross household income equal to or greater than 200% of FPL and equal to less than 400% of FPL must have been eligible for health care services under A.R.S. § 11-297 for at least 12 consecutive months out of the prior 15 consecutive months immediately preceding the month of application for the PSDP.
~~c.~~ b. Medical ~~Verification.~~ verification. ~~An applicant~~ A member who is chronically ill shall submit a written statement from a physician indicating that the ~~applicant's~~ member's illness meets the definition of chronic disease as specified in R9-30-102.
~~d.~~ c. Premium. A chronically ill ~~applicant~~ member and each household member whose gross household income is ~~at~~ equal to or ~~below~~ less than 400% of the FPL but greater than 200% of the FPL shall pay the full premium ~~for each applicant and each household member~~ as specified in ~~Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

~~e.~~ d. Failure to claim chronic disease. ~~Chronically ill applicants~~ A chronically ill member who ~~fail~~ fails to state that ~~they have~~ the member has 1 of the chronic diseases as specified in ~~Laws 1997, Ch. 186 § 3, as amended by Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, and R9-30-102 at the time of application may be denied or referred to the PSA for potential fraud.

R9-30-304. Enrollment

A Premium Share member shall pay the premiums and copayments as specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, for continued enrollment in the PSDP.

1. Health ~~Plan~~ plan choice. ~~An applicant shall select a health plan at the time of application. All eligible household members will be enrolled with the same plan. A Premium Share member shall have freedom of choice of a PSDP contractor when there is 1 or more contractors in the service area.~~
   a. Each eligible household unit shall select a health plan at the time of application.
   b. PSA shall enroll all eligible household members with the same health plan.
   c. Each eligible household unit shall have freedom of choice of a PSDP health plan when there are 1 or more health plans in the service area.
2. Open enrollment. ~~Each eligible household unit will have the opportunity to switch to a new health plan 12 months after the household unit's initial enrollment and each year thereafter.~~ The household unit may change contractors during the annual enrollment choice period.

R9-30-305. Disenrollment

A Premium Share member ~~will~~ shall be disenrolled ~~for~~ from the PSDP as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

1. Reasons for disenrollment. A Premium Share member ~~will~~ shall be disenrolled from the PSDP when eligibility criteria, as specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, are no longer met:
   a. ~~Non-payment~~ Nonpayment of premiums and copayments;
   b. Moving out of the participating counties served by the PSDP;
   c. ~~Provision of~~ Providing false or fraudulent information on the Premium Sharing application;
   d. ~~Two~~ 2 submissions of a ~~returned~~ check returned for non-sufficient funds during enrollment;
   e. No longer meeting the eligibility ~~requirements; or~~ requirements; identified in R9-30-303;
   f. The PSDP ~~expires.~~ expires; or
   g. Failure or refusal to cooperate in the eligibility process or provide requested information.
2. Exception. A Premium Share member who is confined to a hospital on the effective date of disenrollment shall continue to receive coverage until ~~a determination by the contractor's Medical Director or designee,~~ the contractor's Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was ~~admitted.~~ admitted or the Premium Share member is discharged from the hospital.
3. Grievance and appeal process. A Premium Share member has a right to file a grievance or appeal as specified in R9-30-601 et seq.
4. PSDP participation. A Premium Share member who has been disenrolled from the PSDP ~~will~~ shall not be allowed to re-enroll for a period of 12 consecutive months. The 12-month period begins with the date of disenrollment and continues for 12 full calendar months as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.
5. Health Insurance Portability and Accountability Act (HIPAA) of 1996. A Premium Share member who has been disenrolled shall be allowed to use enrollment in the PSDP as creditable coverage as defined in P.L. 104-191 as specified in ~~Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

R9-30-306. Redetermination

A. The PSA ~~will~~ shall conduct a redetermination of eligibility on each Premium Sharing household unit once every 6 months as specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, unless the household unit becomes ineligible prior to this time.

B. The 6-month period ~~will~~ shall begin with the month the ~~applicant~~ household unit is enrolled.

C. The PSA ~~will~~ shall conduct a redetermination on a Premium Share household unit when a Premium Share member moves from 1 PSDP county to another participating PSDP county. ~~A Premium Share member hall shall remain enrolled in the PSDP if they meet the eligibility criteria. The Premium Share member shall have a redetermination completed 6 months from the new date of eligibility.~~

D. A Premium Share member shall remain enrolled in the PSDP if the member continues to meet the criteria in this Article. The Premium Share member shall have a redetermination completed 6 months from the new date of eligibility.

ARTICLE 4. CONTRACTS

R9-30-401. General Provisions

A. Requirements. The PSA and qualified providers of health care who have contracts to provide services under AHCCCS shall conform to the requirements in this Article and ~~Laws 1997, Ch. 186 §§ 3 and 4, as amended by Laws 1997, 2nd Special Session, Ch. 186 §§ 3 and 4.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21. A contractor that has contracts and subcontracts entered into in accordance with this Article shall have records on file.

B. Contract. A contract may be cancelled or rejected in whole or in part, as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.

C. Damages or ~~Claims.~~ claims. Offerors as defined in R9-22-106(5) shall have no right to damages or basis for any claims against the state, ~~it's~~ its employees, or agents, arising out of any action by the PSA ~~according to~~ under the provisions of subsection (B).

R9-30-403. PSA's Contracts with Contractors

A. As specified in ~~Laws 1997, Ch. 186 § 3,~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21, the AHCCCS Administration is authorized to contract with ~~contractors that contract with the AHCCCS Administration~~ AHCCCS' Health Plans ~~according to~~ under A.R.S. § 36-2912.

B. If the Director determines there is insufficient coverage in a county participating in the PSDP, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSDP, as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

C. Each contract between the PSA and a contractor shall be in writing and contain at least the following information:
   1. The method and amount of compensation or other consideration to be received by the contractor;
   2. The name and address of the contractor;
   3. The population to be covered by the contract;
   4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;
   5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination;
   6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract;
   7. A description of ~~a Premium Share~~ member, medical and cost record-keeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the ~~contract.~~ contract; ~~These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, 5 years after the date of final disposition or resolution of the exception;~~
   8. Records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, 5 years after the date of final disposition or resolution of the exception;
   ~~8.~~ 9. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the PSA during normal business hours at the place of business of the person or organization maintaining the records;
   ~~9.~~ 10. A provision that the contractor safeguard information;
   ~~10.~~ 11. A provision that the contractor arrange for the collection of any required copayment by the provider;
   ~~11.~~ 12. A provision that the contractor will not bill or attempt to collect from a Premium Share member for any covered service except as may be authorized by statute or rules in this Chapter;
   ~~12.~~ 13. A provision that the contract will not be assigned or transferred without the prior approval of the Director;
   ~~13.~~ 14. Procedures and criteria for terminating the contract;
   ~~14.~~ 15. Procedures for terminating ~~enrollment and choice of health professional;~~ enrollment;
   16. Procedures for choice of health professionals;
   ~~15.~~ 17. A provision that a contractor provide for an internal grievance procedure that:
      a. Is approved in writing by the PSA;
      b. Provides for prompt resolution; and
      c. Ensures the participation of ~~individuals~~ persons with authority to require corrective action;
   ~~16.~~ 18. A provision that the contractor maintain an internal quality management system;
   ~~17.~~ 19. A provision that the contractor submit marketing plans, procedures, and materials to the PSA for approval before implementation;
   ~~18.~~ 20. A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge;
   ~~19.~~ 21. A provision that the contractor is responsible for all:
      a. Tax obligations;
      b. Workers' Compensation Insurance; and
      c. All other applicable insurance coverage, for itself and its employees, and that the PSA has no responsibility or liability for any of the taxes or insurance coverage; and
   ~~20.~~ 22. A provision that the contractor agrees to comply with all ~~applicable statutes and rules.~~ applicable statutes, rules and policies.

R9-30-404. Subcontracts

A. Approval. A contractor entering into a subcontract to provide services to a Premium Share member must meet the requirements specified in the contract. ~~Any~~ A subcontract and any amendment to a subcontract shall be subject to review and approval by the Director.

B. Subcontracts. Each subcontract shall be in writing and include:
   1. The subcontract that is to be governed by, and construed in accordance with all laws, rules, policies, and contractual obligations of the contractor;
   2. Provision to notify the PSA in the event the subcontract is amended or terminated;
   3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the PSA;
   4. Provision to hold harmless the state, the Director, the PSA, and a Premium Share member in the event the contractor ~~cannot~~ can not or will not pay for covered services performed by the subcontractor;
   5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or cancelled by the Director for a violation of these rules;
   6. Provision to hold harmless and indemnify the state, the Director, the PSA, or a Premium Share member, through the negligence of the subcontractor;
   7. Provision that a Premium Share member is not to be held liable for payment to a ~~provider~~ subcontractor in the event of contractor's bankruptcy;
   8. The method and amount of compensation or other consideration to be received by the subcontractor;
   9. The amount, duration, and scope of medical services to be provided by the subcontractor, for which compensation will be paid; and
   10. The requirements contained in R9-30-403(C)(1) through ~~(13)~~ (14) and ~~(C)(18)~~ (C)(20) through ~~(20)~~ (22) ~~substitute~~ but substituting the term "subcontractor" wherever the term "contractor" is used.

R9-30-406. ~~Mergers; Reorganizations; Change;~~ Merger, Reorganization, Change in Ownership, and Contract Amendments

A. ~~Merger; Reorganization; or Change.~~ Merger, reorganization, or change in ownership. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a contractor.

B. Amendment. The Director shall prior approve any proposed merger, reorganization, or change in ownership ~~or~~ of a subcontractor that is related to or affiliated with the contractor and shall require a contract amendment. To be effective, contract amendments shall be in writing and executed by the Director.

R9-30-407. ~~Suspension; Denial; Modification;~~ Suspension, Modification, or Termination of Contract

Contract

A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good ~~cause as specified in contract.~~ cause.

B. Modification and termination of the contract without cause. The AHCCCS Administration and contractor, by mutual consent, may modify or terminate the contract at any time without cause. Additionally, the AHCCCS Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.

C. Notification.
1. The Director shall provide the contractor written notice ~~of:~~ of intent to:
   a. ~~Intent to suspend;~~ Suspend;
   ~~b. Deny;~~
   ~~e~~ b. Fail to renew; or
   ~~d~~ c. Terminate a contract or related subcontract.
2. The PSA shall provide a notice to ~~affected principals~~ a contractor, a Premium Share member, and other interested parties, and shall include:
   a. The effective date; and
   b. Reason for the action.

D. Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.

R9-30-408. Contract Compliance Sanction Alternative

The Director may impose a sanction ~~to~~ upon a contractor that violates any provision of the rules as specified in contract.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-502. Availability and Accessibility of Services

A. A contractor shall provide adequate numbers of available and accessible:
1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.

B. A contractor shall minimally provide the following:
1. ~~The requirements~~ A ratio of the number of primary care providers to the number of adults and children, ~~may be~~ as specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to a Premium Share member in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;
3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to a Premium Share member who needs information in an emergency, and to a provider who needs verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
   a. Premium Share member's name;
   b. Address and telephone number;
   c. Date and time of call;
   d. Nature of complaint or problem; and
   e. Instructions given to a Premium Share member; and
5. A written procedure for communicating emergency services information to a Premium Share member's primary care provider, and other appropriate organizational units.

C. A contractor shall have an affiliation with or subcontract with an organization or ~~individual~~ person to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction as specified in contract. ~~A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contractor, within the service area of the contractor.~~

R9-30-504. Marketing

The PSA shall require a contractor to develop a marketing plan as specified in ~~Laws 1997, Ch. 186, § 3~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21 and as specified in contract.

R9-30-507. Member Record

A contractor shall maintain a Premium Share member service record that contains at least the following for each Premium ~~Sharing~~ Share member:
1. Encounter data, if required by PSA;
2. Grievances and appeals;
3. Any informal complaints; and
4. Service information.

R9-30-509. Transition and Coordination of Member Care

The PSA shall coordinate and implement disenrollment and reenrollment procedures when a Premium Share member's change of ~~residency~~ residence requires a change in contractor as specified in contract.

R9-30-510. Transfer of a Member

A contractor shall implement procedures to allow a Premium Share member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:
1. Change in the Premium Share member's health, requiring a different medical focus;
2. Change in the Premium Share member's ~~residency~~ residence resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the Premium Share member and the primary care provider, resulting

in deterioration of the primary care provider member relationship.

R9-30-511. Fraud and Abuse

A contractor, provider, or ~~nonprovider~~ noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse as specified in R9-30-303.

R9-30-512. Release of Safeguarded Information by the PSA and a Contractor

A. The PSA, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant, or a Premium Share member, which includes the following:
   1. Name and address;
   2. Social Security number;
   3. Social and economic conditions or circumstances;
   4. Agency evaluation of personal information;
   5. Medical data and services, including diagnosis and history of disease or disability;
   6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
   7. Information system tapes from the Arizona Department of Economic Security, if required;

B. The restriction upon disclosure of information does not apply to:
   1. Summary data;
   2. Statistics;
   3. Utilization data; and
   4. Other information that does not identify a Premium Share member.

C. The PSA, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning a Premium Share member only under the conditions specified in subsection (D), (E), and (F) and only to:
   1. The person concerned;
   2. ~~Individuals~~ Persons authorized by the person concerned; and
   3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released to only:
   1. An applicant;
   2. A Premium Share member; or
   3. A dependent child, with written permission of a parent, custodial relative, or designated representative, if:
      a. ~~If a~~ A PSA employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
      b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

E. An eligibility case record, medical record, and any other PSDP-related confidential and safeguarded information regarding Premium Share member or applicant, shall be released to ~~individuals~~ persons authorized by the Premium Share member or applicant, only under the following conditions:
   1. Authorization for release of information is obtained from the Premium Share member, applicant, or designated representative;
   2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
      a. Information or records, in whole or in part, which are authorized for release;
      b. To whom release is authorized;
      c. The period of time for which the authorization is valid, if limited; and
      d. A dated signature of the adult and mentally competent Premium Share member, applicant, or designated representative. If a Premium Share member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If a Premium Share member or applicant is mentally incompetent, authorization shall be ~~according to~~ under A.R.S. § 36-509; or
   3. If an appeal or grievance is filed, the Premium Share member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:
   1. Official purposes directly related to the administration of the PSDP are:
      a. Establishing eligibility and post-eligibility treatment of income, as applicable;
      b. Providing services for a Premium Share member;
      c. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the PSDP program; and
      d. Performing evaluations and analyses of PSDP operations;
   2. For official purposes related to the administration of the PSDP program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, or Premium Share member:
      a. Employees of the PSA;
      b. Employees of the AHCCCS Administration;
      c. Employees of the U.S. Social Security Administration;
      d. Employees of the Arizona Department of Economic Security;
      e. Employees of the Arizona Department of Health Services;
      f. Employees of the U.S. Department of Health and Human Services;
      g. Employees of contractors, program contractors, providers, and subcontractors; and
      h. Employees of the Arizona Attorney General's Office, and the County Attorney, if applicable.
   3. Law enforcement officials:
      a. Information may be released to law enforcement officials without the applicant's or Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the PSDP program.
      b. The PSA and contractors shall release safeguarded information contained in an applicant's or Premium Share member's medical record to law enforcement officials without the Premium Share member's consent only if the applicant or Premium Share member is suspected of fraud or abuse against the PSDP program.

c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the PSA, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The PSA may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or Premium Share member.
5. Providers shall furnish requested records to the PSA and its contractors at no charge.

G. The holder of a medical record of a former applicant or Premium Share member shall obtain written consent from the former applicant, or Premium Share member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a Premium Share member before transmitting the Premium Share member's medical records to a physician who:
1. Provides a service to the Premium Share member under subcontract with the contractor;
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and
3. Provides a service under the contract.

R9-30-514. Equal Opportunity

A contractor shall meet the requirements in ~~Title VI~~ Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C. ~~5000(e).~~ 2000(e). A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:
1. Specify that it is an equal opportunity employer;
2. Send a notice ~~provided by the PSA~~ to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

R9-30-518. Information to an Enrolled Member

A. Each contractor shall produce and distribute a printed member handbook to each household unit ~~by~~ within 10 days of the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the contractor shall only be liable for services authorized by a Premium Share member's primary care provider or the contractor;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the Premium Share member, and a description of the selection process, including a statement that informs the Premium Share member they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the contractor's service area;
6. The causes for which a Premium Share member may lose coverage;
7. A description of the grievance procedures;
8. Copayment schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the contractor; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each contractor shall prepare and distribute to a Premium Share member, a printed member handbook insert describing any changes that the contractor proposes to make in services provided within the contractor's service area. The insert shall be distributed to all household units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

R9-30-523. Financial Resources

A. A contractor or offeror shall demonstrate upon request ~~to~~ by the PSA that it has:
1. Adequate financial reserves;
2. Administrative abilities; and
3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2912, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits;
2. Performance bonds unless waived as specified in A.R.S. § 36-2912;
3. Financial reserves; or
4. Other financial security, unless waived as specified in A.R.S § 36-2912.

ARTICLE 6. GRIEVANCES AND APPEALS

R9-30-601. General Provisions for all Grievances and Appeals

A. General Requirements. All grievances and appeals regarding Premium Sharing shall be filed and processed in accordance with A.A.C. R9-22-801. All references in that rule to AHCCCS also shall apply to PSA, and all references to health plans and system providers shall also apply to Premium Sharing Plans. In eligibility appeals, PSA is the respondent.

B. The AHCCCS Chief Hearing Officer or designee may deny a request for hearing if the sole issue presented is a state law requiring an automatic change adversely affecting some or all applicants or ~~a~~ Premium Share ~~member.~~ members.

R9-30-602. Eligibility Appeals and Hearing Requests for an Applicant and a Premium Share Member

A. Adverse eligibility action. An applicant and a Premium Share member may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
2. Discontinuance of eligibility;
3. Determination of premium amount; or
4. Chronic illness determination.

B. Notice of an adverse eligibility action. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected ~~individual~~ person by regular mail. For purposes of this Section, the date of the notice of action shall be the date of personal delivery to the ~~individual~~ person or the postmark date, if mailed.

C. Appeals and requests for hearing.

1. The applicant or a Premium Share member may appeal and request a hearing regarding any adverse eligibility action by completing and submitting the premium sharing request for hearing form or by submitting a written request containing the following information:
   a. The case name;
   b. The adverse eligibility action being appealed; and
   c. The reason for appeal.
2. The Request for Hearing shall be filed not later than 15 days after the date of the notice of adverse action by mailing or delivering it to the PSA, Office of ~~Grievance and Appeals~~ Legal Assistance. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. PSA responsibilities.
1. The PSA shall maintain a register which documents the dates on which requests for hearings are submitted.
2. If requested, the PSA shall assist the applicant or a Premium Share member in the completion of the request for hearing form.
3. The pre-hearing summary shall be completed by the PSA and shall summarize the facts and factual basis for the adverse eligibility action.
4. The PSA shall send to the Office of ~~Grievance and Appeals,~~ Legal Assistance, the pre-hearing summary, a copy of the case file, documents pertinent to the adverse action, and the request for hearing, which must be received by ~~the,~~ the Office of ~~Grievance and Appeals~~ Legal ~~Assistance,~~ Assistance not later than 10 days from the date of the receipt of the request. If the request is submitted directly to the Office of ~~Grievance and Appeals,~~ Legal Assistance, the PSA shall send the materials to the Office of ~~Grievance and Appeals,~~ Legal Assistance, not later than 10 days from the date of a request for the materials.

E. PSDP coverage during the appeal process.
1. A Premium Share member appealing a discontinuance. A discontinuance is a termination of Premium Sharing benefits. If a Premium Share member requests a timely hearing, the Premium Share member shall receive continued Premium Sharing benefits until an adverse decision on appeal is rendered only if the Premium ~~Sharing~~ Share member pays for 3 months worth of premiums, by cashier's check, personal check, or money order, within 15 days of the mailing of the notice of discontinuance.
2. An applicant appealing a denial of Premium Sharing coverage. A denial is an adverse eligibility decision which finds the applicant ineligible for PSDP benefits. In the event that a timely request for hearing is filed, and the denial is overturned, the effective date of PSDP coverage shall be established by the Director in accordance with applicable law.
3. A Premium Share member whose benefits have been continued shall be financially liable for all PSDP benefits received during a period of ineligibility, if a discontinuance decision is upheld by the Director.

R9-30-603. Grievances

General Requirements. All grievances regarding PSDP shall be filed and processed in accordance with A.A.C. R9-22-804. All references in that rule to AHCCCS also shall apply to the PSA, and all references to contractors shall also apply to PSDP contractors.

ARTICLE 7. PAYMENT RESPONSIBILITIES

R9-30-701. A Premium Share Member's Payment Responsibilities

A. Premium payment requirement. A Premium Share member shall pay the required premium payment established by the PSA as specified in ~~Laws 1997, Ch. 186 § 3 as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

B. ~~Premium~~ Monthly premium payment based on annual household income ~~under~~ equal to or less than 200% of ~~FPL.~~ FPL, determined by the 3-month income period. A Premium Share member whose gross household income ~~does not exceed~~ equal to or less than 200% of the FPL will pay a share of the premium. The ~~premium share~~ Premium Share member will pay the share of the premium depending on the number of eligible ~~individuals~~ persons in the household, and the gross household income.
1. For 1 eligible household member, the premium share will be equal to 2.5% of the gross household income;
2. For 2 eligible household members, the premium share will be equal to 3.0% of the gross household income;
3. For 3 eligible household members, the premium share will be equal to 3.5% of the gross household income;
4. For 4 or more household members, the premium share will be equal to 4% of the gross household income.

C. Premium payment for chronically ill person ~~between~~ with gross household income greater than 200% and equal to or less than 400% of FPL. The PSA will require the chronically ill ~~enrollees~~ members and their household members whose gross household income is ~~between~~ greater than 200% and equal to or less than 400% of the FPL to pay the full premium as established by the PSA.

D. Premium payment schedule. The PSA requires that upon conditional approval of the application, the Premium Share member must pay the premium for the 1st 2 months of coverage. If the PSA receives the premium payment on or before the 15th day of the month, enrollment will begin on the 1st day of the next month. If the PSA receives the premium payment after the 15th day of the month, coverage begins on the 1st day of the 2nd month.

E. When and how to submit premium. The Premium Share member shall submit their monthly premium payment to the PSA at least 30 days in advance of the coverage month.
1. All premiums paid in advance by the Premium Share member are ~~non-refundable,~~ nonrefundable, unless the Premium Share member is disenrolled at least 15 days prior to the month of coverage. Premiums paid during a grievance under R9-30-602(E) will not be reimbursed.
2. A Premium Share member's monthly premium ~~must~~ shall be paid with sufficient funds in the form of a:
   a. Cashier's check;
   b. Personal check; or
   c. Money order.

F. Newborns. All newborns shall be enrolled within 31 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the PSA within 31 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

G. Copayment requirements. A Premium Share member shall pay the following copayments as specified in ~~Laws 1997, Ch. 186 § 3:~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21:
1. $10 for each physician visit;
2. $25 for each emergency room visit. This fee shall be waived if the person is admitted to the hospital;
3. $50 for each inpatient stay;

4. $50 for each emergency room visit that is for a non-emergency situation;
5. $3 for each prescription that is filled with a generic drug, and 50% of the cost of each prescription that is filled with a brand name pharmaceutical, unless a generic drug is unavailable or not medically appropriate, in which case the ~~enrollee~~ Premium Share member shall pay $3 for each prescription;
6. $8 for each laboratory ~~visit;~~ visit not to exceed $8 per site per day or a maximum copayment of $10 per day for a laboratory visit made on the same day in conjunction with a physician visit;
7. $8 for each x-ray ~~service;~~ service not to exceed $8 per site, per day or a maximum copayment of $10 per day for a x-ray service made on the same day in conjunction with a physician visit;
8. $50 for each behavioral health admission to an inpatient behavioral facility. ~~Enrollees~~ Premium Share members are eligible for a maximum of 30 days of inpatient behavioral health services annually;
9. $10 for individual outpatient behavioral health services. ~~Enrollees~~ Premium Share members are eligible for a maximum of 30 outpatient behavioral health visits annually;
10. $5 for outpatient behavioral health group services; and
11. The full cost of any nonemergency transportation.

H. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay copayments in full at the time service is rendered as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21.

R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors

A. Liability for covered services. The ~~the~~ AHCCCS Administration and the PSA shall have no liability for the provision of covered services or for the completion of a plan of treatment to a Premium Share member beyond the date ~~of termination of the individual's eligibility or enrollment.~~ of disenrollment except when the Premium Share member is confined to a hospital as specified in R9-30-305(2). The AHCCCS Administration and the PSA shall be liable until care in the hospital is no longer medically necessary for the condition for which the member was admitted.

B. Subcontracts liability. The AHCCCS Administration and the PSA shall have no liability for subcontracts that a contractor may execute with other parties. ~~parties for the provision of:~~
~~1. Administrative or management services;~~
~~2. Medical services;~~
~~3. Covered health care services; or~~
~~4. For any other purpose.~~

C. Contractor's liability for costs. The contractor shall indemnify and hold the AHCCCS Administration and the PSA harmless from any and all liability arising from the contractor's subcontracts, and shall be responsible for:
1. All costs of defense of any litigation concerning the liability; and
2. Satisfaction in full of any judgment entered against the AHCCCS Administration and the PSA in litigation involving the contractor's subcontracts.

D. Capitation rates. The PSA shall establish actuarially sound capitation rates as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1 § 1; Laws 1998, Ch. 214 § 21. The PSA may adjust the initial capitation rates, except that any increase exceeding 10% of the established rate must 1st be reviewed by the oversight committee as specified in ~~Laws 1997, Ch. 186 § 3.~~ Laws 1997, Ch. 186 § 5.

E. Payments. The PSA shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the PSA and in accordance with these rules.

F. Medical financial risk. The PSA will limit the medical financial risk to contractors associated with the PSDP through a ~~reconciliation~~ risk sharing reconciliation arrangement as specified in contract.

G. Payments made on behalf of a contractor; recovery of indebtedness. The PSA may make payments on behalf of a ~~contract~~ contractor in order to prevent a suspension or termination ~~or~~ of services as specified in A.A.C. R9-22-713.

H. Specialty contracts and payments. The PSA may at any time negotiate or contract for specialty contracts on behalf of providers, and noncontracting providers. The PSA and a contractor shall meet the requirements in A.A.C. R9-22-716.

I. Charges against a Premium Share member. A contractor, subcontractor, or other provider ~~of care~~ of services shall not:
1. Charge;
2. Submit a claim; or
3. Demand or otherwise collect payment from a Premium Share member or person acting on behalf of a Premium Share member for any covered service except to collect an authorized copayment or payment for a ~~non-covered~~ noncovered service. A ~~prepaid capitated~~ contractor who makes a claim ~~under this provision~~ for a noncovered service shall not charge more than the actual, reasonable cost for providing the service.

J. Collecting payment. Except for copayments under R9-30-701(F), a provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from ~~an individual~~ a person claiming to be a Premium Share member without 1st receiving verification from the PSA that the ~~individual~~ person was ineligible for PSDP on the date of service or that the services provided were not covered by PSDP.

K. Premium Share member withheld information. The prohibition in Section (J) shall not apply if the PSA determines that the Premium Share member willfully withheld information pertaining to the Premium Share member's enrollment with a contractor. A prepaid capitated contractor shall have the right to recover from a Premium Share member that portion of payment made by a 3rd-party to the Premium Share member when the payment duplicates the PSDP benefits and the payment has not been assigned to the contractor.

R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

A. General responsibilities. A provider shall submit to a contractor all claims for services rendered to a Premium Share member enrolled with the contractor. A contractor shall pay for all admissions and covered services provided to a Premium Share member when the admissions or covered services have been arranged and necessary authorization has been obtained by:
1. A contractor's agent or employee;
2. A subcontracting provider; or
3. Other ~~individual~~ person acting on the ~~contractor's~~ subcontractor's behalf.

B. Claims.
1. Time-frame to pay a claim. A contractor shall reimburse subcontracting and noncontracting providers for the provision of covered ~~health care~~ services to a Premium Share member either:

a. Within the time period specified by contract between a contractor and a subcontracting entity; or
b. Within 60 days of receipt of a clean claim, if a time period is not specified in contract; or
c. For a hospital claim, a contractor shall pay a non-contracting provider for inpatient hospital and outpatient hospital services according to the quick pay discount and slow pay penalties as specified in A.R.S. § 36-2903.01(J).

2. When a contractor is not required to pay a claim. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service, or that is submitted as a clean claim more than 12 months after the date of service.
3. Inpatient or outpatient hospital claim. A contractor shall pay the hospitals in accordance with:
a. How a hospital claim is processed ~~according to~~ under A.A.C. R9-22-705;
b. What personal care items are covered ~~according to~~ under A.A.C. R9-22-717; and
c. What hospital supplies and equipment are covered ~~according to~~ under A.A.C. R9-22-717.
4. Review of hospital claims. If a contractor and a hospital do not agree on reimbursement levels, terms and conditions, the requirements specified in A.A.C. R9-22-705 shall apply.
5. Denial and rights of a claimant. A contractor shall provide written notice to a provider whose claim is denied or reduced by the contractor within 60 days of receipt of a claim. This notice shall include a statement describing the provider's right to:
a. Grieve the contractor's rejection or reduction of the claim; and
b. Submit a grievance in accordance with A.A.C. R9-22-804.

C. Reimbursement.
1. In-state inpatient hospital reimbursement. A contractor shall reimburse an in-state subcontractor and noncontracting provider for the provision of inpatient hospital services. The contractor may choose among the following reimbursement methodologies depending on the county in which the services are provided.
a. Maricopa and Pima counties.
i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
ii. Reimbursement based on the pilot program described in A.A.C. R9-22-718.
b. Cochise and Pinal counties.
i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
ii. The prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712.

2. Payment for emergency services and subsequent care. A contractor shall pay for all emergency care services provided to a Premium Share member by subcontracting and noncontracting providers when a service:
a. Conforms to the notification requirements in 9 A.A.C. 30, Article 2;
b. Conforms to the definition of emergency medical services defined in 9 A.A.C. 22, Article 1;
c. Meets the requirements in A.A.C. R9-22-709 - Contractor's Liability for Hospital for the Provision of Emergency and Subsequent Care; and
d. Is provided in the most appropriate, cost-effective, and least restrictive setting.
3. Observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days that do not result in an admission at:
a. A rate specified by subcontract; or
b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
4. Outpatient hospital reimbursement. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either:
a. A rate specified by subcontract. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
5. Out-of-state hospital reimbursement. A contractor shall reimburse an out-of-state hospital for the provision of inpatient and outpatient hospital services at:
a. The lower of the negotiated discounted rates; or
b. 80% of billed charges.

D. Transfer of payments. The PSA or a contractor shall meet the requirements in A.A.C. R9-22-704.